DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 05A419 | A. BUILDING _____ B. WING _____ | 04/23/2008 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| VETERANS HOME OF CALIFORNIA - BARSTOW | 100 EAST VETERANS PARKWAY BARSTOW, CA 92311 |

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| F 000 | INITIAL COMMENTS<br><br>The following reflects the findings of California Department of Public Health during a Recertification survey.<br><br>Representing California Department of Public Health:<br><br>Manny Dumangas, HFEN<br>Lloyd Biggs, HFEN<br>Naomi Russell, HFEN<br>Joan Jones, Pharmaceutical Consultant<br><br>Census: 55<br>Resident Sample Size: 14 | F 000 | Preparation and execution of this plan of correction in no way constitutes an admission or agreement by the Veterans Home of California-Barstow of the truth of the facts alleged in this statement of deficiencies and plan of correction. This plan of correction is submitted to comply with State and Federal law. This plan of correction serves as our credible allegation of compliance. | |
| F 253<br>NE | 483.15(h)(2) HOUSEKEEPING/MAINTENANCE<br><br>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and facility staff interview, the facility failed to maintain a sanitary environment when it failed to provide specific resident identification to toothbrushes, hand held urinals and razors.<br><br>Findings:<br><br>On the morning of 4/14/08 during initial tour, the following was observed: an unlabeled hand-held urinal in the bathroom shared by multiple resident rooms 612 and 613, an unlabeled hand-held urinal in the bathroom shared by multiple resident rooms 606 and 607, two manual toothbrushes and a disposable razor without specific resident | F 253 | F 253, 483.15(h)(2)<br>*Housekeeping/Maintenance: It is the policy of the Veterans Home of California-Barstow to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable environment.*<br><br>Corrective Action<br>Please note on April 14, 2008, the items in rooms 612, 613, 606, and 607, were immediately labeled with the appropriate resident's name. In order to enhance currently compliant operations, under the direction of the director of nurses, all nursing staff<br>(cont. next page) | 6-4-08 |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Jaime J. Todd, LNHA | Administrator | 5/19/2008 |

any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| F 253 | Continued From page 1<br>identification in multiple resident room 606 and one electric and one manual toothbrush without resident specific identification in room 608.<br><br>At the times of discovery facility nursing staff acknowledged the potential for the unsanitary practice of residents sharing these personal hygiene items. | F 253 | [ F 323 Starts next page]<br><br>will received refresher training regarding procedures for labeling residents belongings on or before June 4, 2008. | |
| F 323 SS=D | 483.25(h) ACCIDENTS AND SUPERVISION<br><br>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and record review, the facility failed to ensure that 1 of 14 sampled residents (Resident 8) who was reported and documented to be consuming alcohol and had multiple incidents of fall inside and outside the facility receives adequate supervision to prevent accidents.<br><br>Findings:<br><br>On 4/15/08 at 8 a.m., an observation of Resident 8 was conducted. Resident 8 was observed in the group area of Pod 400, dressed appropriately and talking with the staff. The resident was also observed to be alert, oriented, and communicating without difficulty. Resident 8 was then observed walking to his room independently and without use of any assistive device. | F 323 | Procedure for identifying other residents potentially affected<br>On April 14, 2008, a designated nursing staff was assigned to complete an audit of all toothbrushes, razors, and urinals to verify proper labeling and storage procedures.<br><br>Systemic Changes and Quality Assurance Monitoring<br>Under the direction of the director of nurses, a weekly inspection of five randomly selected resident rooms will be conducted to verify that residents are storing hygiene items properly. The results of these inspections will be documented and submitted to the quality assurance committee for further review and corrective action.<br>(cont. next page) | |

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| F 323 | Continued From page 2<br><br>On 4/15/08 at 9 a.m., a clinical record review of Resident 8 was conducted. The review indicated that Resident 8 is an 86 year old male who was originally admitted in the facility on 2/26/06 with diagnoses of Generalized Pain, Congestive Heart Failure (CHF), Hypertension (HTN), Coronary Arterial Disease (CAD), Chronic Obstructive Pulmonary Disease (COPD), Dyslipidemia, Depression, and Anxiety.<br><br>On the same date and time, a review of Resident 8's Medication Recap Report dated 11/14/07 was conducted. The review indicated that there was an order by the physician that Resident 8 may go outside the facility on pass with a responsible party. On the same date and time, another review of the Medication Recap Report dated 3/29/08 was conducted. The review indicated that Resident 8 is taking multiple medications which include: Vicodin for generalized pain, Aldactone and Lasix for CHF, Toprol XL for HTN, Amiodarone for Cardiac Arrhythmia (abnormal heart rhythm), Nitroglycerin for chest pain, Crestor for Hypercholesterolemia (high cholesterol), Celexa, Cymbalta, Seroquel, Trazodone for Depression, and Ativan for Anxiety. On the same report, a hand written addendum was made on 3/29/08 at 3 p.m., it indicated, "Librium 25 mg (milligram) PO (by mouth) 1 TID (three times a day) (ETOH [Alcohol] withdrawal x 1 wk [week])."<br><br>On the same date and time, a review of Nursing Notes was conducted. The review indicated three incidents of fall by Resident 8, as follows:<br>1. On 2/13/08 at approximately 9:30 a.m., Resident 8 tripped and fell in the parking lot of Psychiatrist's office outside the facility. | F 323 | F 323, 483.25(h) *Accidents and Supervision: It is the policy of the Veterans Home of California-Barstow to strive to maintain an environment as free of accidental hazards as possible and provides adequate supervision and assistive devices as reasonably possible.*<br><br>Corrective Action<br>Please note that resident number 8 does not drink every day. The resident does have a history of sneaking alcohol into his room on occasion. The doctor's note of March 29, 2008, stating that the resident drank every day was a self report from the resident, which was a concerted effort for medication-seeking (IDT note 3/28/08) which is a common practice of substance abusers. In order to enhance currently compliant operations, the resident was offered to receive inpatient treatment for substance abuse at the VA Medical center. A care plan was developed on April 17, 2008, to provide staff interventions to address alcohol related (cont. next page) | 4-22-08 |

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| F 323 | Continued From page 3<br>2. On 3/2/08 at 2:35 a.m., Resident 8 fell against his bed hitting his rib and head on the floor.<br>3. On 3/2/08 at 11 a.m., Resident 8 was holding his drink while bending to get something from the drawer, lost his balance, and rolled to the floor.<br><br>On 4/16/08 at 9:55 a.m., an interview with the Certified Nursing Assistant 1 (CNA1) was conducted. CNA1 stated that she's been taking care of Resident 8 on and off for less than a year. She also stated that she had never observed Resident 8 having problems with his speech or gait while taking care of him during morning shift.<br><br>On 4/16/08 at 10 a.m., an interview with the Certified Nursing Assistant 2 (CNA2) was conducted. CNA2 stated that Resident 8 spend most of his time in his room. CNA2 further stated that she had not observed Resident 8 intoxicated, unsteady gait, and slurred speech while taking care of him during morning shift.<br><br>On 4/16/08 at 10:25 a.m., a review of the Fall Risk Screening Tool dated 3/2/08 and 3/7/08 was conducted. The record indicated that it is used as a form of assessment to identify resident who are at high-risk for fall. The record further indicated, "Instructions: 3. Add points under total score. Indicate care planning needed if fall risk total is 10 or above." Resident 8, based on this assessment, was identified to have a total score of 9 and 8 consecutively which is below the 10 category mark. On the same date and time, a review of the Falling Star Prevention Program dated 3/2/08 was conducted. The review indicated that Resident 8 was included in the program and the goal was to have no more further falls. | F 323 | problems. An interdisciplinary team meeting was held on April 22, 2008, and the resident was educated regarding the dangers of mixing alcohol with medication, particularly, the potential adverse drug reactions. Resident gave an oral contract to refrain from any further use of alcohol. Additionally, nursing staff received in-service training on the new care plan beginning April 17, 2008. Furthermore, to safeguard the resident in the event he is observed intoxicated, he will be placed on a 1:1. The facility will then initiate an emergency Code of Conduct process and facilitate an emergency IDT to evaluate for further clinical remedies. If the IDT determines resident is a danger to himself or others, the Veterans Home administrative staff will convene to discuss the potential for discharge proceedings. (cont. next page) | |

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| F 323 | Continued From page 4<br><br>On 4/16/08 at 11:20 a.m., an interview with the Unit Physician was conducted. The Unit Physician stated, "Resident 8 has a psychiatric disorder which includes two extremes, Anxiety and Depression." The Unit Physician also stated that on 3/28/08, four bottles of hard liquor were found in the room of Resident 8 and believe to be ingesting alcohol along with his psychotropic, pain, and cardiac medications. The Unit Physician further stated that Librium was ordered for Resident 8's ETOH (alcohol) withdrawal.<br><br>On 4/16/08 at 11:45 a.m., a review of the Physician's Orders dated 3/8/08 was conducted. The record indicated, "Blood ETOH level." The order was made to check Resident 8's blood alcohol level. The entire Physician's Orders were reviewed dating back to 3/07 up to 3/29/08, however, there were no other records found indicating that the facility was continuously monitoring Resident 8's blood alcohol level since he was reported drinking on 3/31/07. On the same date and time, a review of the Physician's Orders written on 3/29/08 was conducted. The record indicated, "Librium 25 mg (milligram) PO (by mouth) 1 q (every) TID (three times a day) for ETOH withdrawal x 1 wk. (week)."<br><br>On 4/16/08 at 1 p.m., a review of the Patient ' s Laboratory Report dated 3/10/08 was conducted. The record showed results from the order made by the physician on 3/8/08 to check Resident 8's blood alcohol level. The record indicated: Test Name = Alcohol, Result = 1, Reference Range = 0.0 - 100, Units = mg/dl<br><br>On 4/16/08 at 1:30 p.m., a review of Nursing Notes was conducted. The review indicated that | F 323 | Procedure for identifying other residents potentially affected<br>On April 22, 2008, the social work staff conducted an audit of all residents' social service evaluation forms to determine those residents with the potential for substance abuse.<br><br>Systemic Changes and Quality Assurance Monitoring<br>Effective April 17, 2008, a quality assurance process was implemented consisting of placing the resident on 4 hour checks, for the first 30 days, and checks every shift thereafter for the next 60 days. During the checks staff will monitor for signs and symptoms of alcohol consumption as outlined in the care plan. If resident is observed to have consumed alcohol the Director of Nurses (DON) will be notified immediately and a 1:1 staff will be assigned to safeguard resident. The resident's room will then be immediately inspected for contraband, which will be confiscated if found. An<br>(cont. next page) | |

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| F 323 | Continued From page 5<br>on 3/31/07 at 9:06 a.m., an entry was made by a staff regarding Resident 8's consumption of alcohol in the facility. The documentation specified, "Resident's wife came to nursing station at 0630 am and reported to this writer that her husband had been drinking all night. Resident room was searched and a bottle of Whiskey was found under bedside table approx. half full and a full bottle of Cream Liqueur was taken from room unopened. Resident assessed for alcohol intoxication. [Unit Doctor] notified at 0830 today with orders to obtain a LFT (Liver Function Test) and Magnesium level on Monday and to have Social Services see resident on Monday. Resident informed that alcohol may not be kept in room and consumed when he wants to. DON (Director of Nursing) informed of above."<br><br>On 4/16/08 at 1:45 p.m., a review of the Report of Consultation documented by the contracted Psychiatrist on 5/24/07 was conducted. The report indicated, "Pt. [Patient] is anxious, c/o (complaint of) wife not doing well and attempting to justify his use of ETOH because of marital problem ... ....." On the same date and time, another review of the Report of Consultation dated 2/13/08 was conducted. The report indicated, " He went walking, tripped and fell down. Refused to go to the hospital." The report was made by the Psychiatrist outside the facility describing the incident of fall Resident 8 had while in the parking lot.<br><br>On the same date and time, another review of Nursing Notes was conducted. The review indicated that on 3/28/08 at 1:54 p.m., another entry was made by a staff regarding Resident 8's consumption of alcohol in the facility. The review indicated, "Housekeeping staff reports while | F 323 | emergency interdisciplinary team meeting will be convened as soon as possible to discuss the resident's continued substance abuse and a determination will be made on potential discharge proceedings. | |

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| F 323 | Continued From page 6<br>cleaning up res. couple room, noted a can of Sparks with alcohol content of 6%. Res. mostly argumentative and medication seeking. When further checked other areas of the room, staff found an empty bottle of Seagrams (1.75 Liters or 40% alcohol); empty bottle of Christian Bros. very smooth; and almost full opened bottle of Vodka (1.75 Liters of 40% alcohol). MD [Unit MD] aware. [Charge Nurse] notified; Supervising Registered Nurse [SRN] notified. [SS], Social services notified, [DON] made aware."<br><br>On 4/16/08 at 2:35 p.m., a review of the Physician's Progress Notes written on 3/29/08 was conducted. The record indicated, "Pt. was taking Vodka, Brandy, Whiskey regularly everyday getting anxious and had frequent falls. C/O withdrawal symptoms like anxiety, shakiness ... ...A/P (Assessment/Plan): ETOH abuse, ETOH Dependence, Plan: D/C (Discontinue Ativan, Xanax, start Librium 25 mg TID."<br><br>On 4/17/08 at 8:45 a.m., an interview with the Licensed Vocational Nurse (LVN) was conducted. The LVN stated that she ' s familiar with Resident 8. She further stated, "I found four bottles of alcohol and 1 of the bottles is almost full (Vodka). They were found inside the closet approximately three weeks ago." She also stated that Resident 8 was very belligerent on the day they found the bottles of alcohol and it was out of Resident 8's character to yell at the LVN, reason why she suspected that the Resident 8 is taking more than his medications. The LVN further stated that she had not observed Resident 8 intoxicated or under the influence during morning and night shift that she was on, however she was told in the past by a family member that the resident has an alcohol problem before coming into the facility. | F 323 | | |

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| F 323 | Continued From page 7<br><br>On 4/17/08 at 9:25 a.m., an interview with the Psychiatric Social Worker (PSW) was conducted. The PSW stated that Resident 8 was counseled in the past for consuming alcohol in the facility. A Code of Conduct Violation Report was also written on 3/28/08 for the consumption of alcohol. An Interdisciplinary Team (IDT) meeting was conducted on 4/15/08 and according to the PSW, Resident 8 denied consuming alcohol or having an alcohol problem, which was reflected in the in the IDT notes. The PSW further stated, "Yes, there's an issue with the resident drinking alcohol in the facility."<br><br>On 4/17/08 at 10 a.m., a review of the IDT Summary dated 6/18/07 was conducted. The review indicated that Resident 8 was admitted to Barstow Community Hospital on 5/9/07 due to his wife falling off the bus into him and knocking him to the ground. The review further indicated, "Last seen by psychiatry 5/24/07, Seroquel added on 5/29 per psychiatry recommendation. Mood and anxiety have settled with the addition of this medication, he reports he is not drinking alcohol ... ..."<br><br>On the same date and time, a review of the IDT Summary dated 2/13/08 was conducted. The review indicated, "At approx. 0930 hr [Psychiatrist] office called and stated that res. fell in the parking lot of their office and that res. had some bruises and scrapes. The psychiatrist further stated that res. was refusing to go to the hospital and wanted to stay for his scheduled appointment."<br><br>On the same date and time, a review of the IDT Summary dated 3/2/08 at 11 a.m. was conducted. | F 323 | | |

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| F 323 | Continued From page 8<br>The review indicated, "Wife yelled for help, stating, "[Resident 8] is on the floor." Saw res. on the floor; asking help for assist to get up. Res. was asked what has transpired. Res. stated, "I was holding my Gatorade drink; at the same time I was bending to get something from the drawer in the closet; and out balanced; and rolled to the floor."<br><br>On the same date and time, another review of the IDT Summary dated 3/2/08 was conducted. The review indicated, "Res. came to the nurses' station. States that he is in severe pain on his Rt. [right] rib cage. Stated he fell against his bed three hours ago and hit his head on the floor. Red area noted on top of the back of his head. Cleaned with soap and H20 [water]. Stated he was getting a cup of water when he lost his balance." | F 323 | | |
| F 329 SS=D | 483.25(l) UNNECESSARY DRUGS<br><br>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.<br><br>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and | F 329 | F 329, 483.25(i) *It is the policy Veterans Home of California-Barstow to provide drug regimens that are free from unnecessary drugs.*<br><br>Corrective Action<br>On April 18, 2008, resident number 11's Ambien order was changed to prn. Also, on April 16, 2008, resident number 10's Benadryl was discontinued. In order to enhance currently compliant operations, under the direction of the director of nurses, all licensed nurses will receive refresher training on policies and procedures for medication administration on or before June 4, 2008. (cont. next page) | 6-4-08 |

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| F 329 | Continued From page 9<br>behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on clinical record review and facility staff interview, 2 of 14 sampled residents . (Residents 11 and 12) received medication for an excessive duration, and/or excessive dosage, and/or without adequate monitoring. Resident 11 received a hypnotic drug (Ambien) for an excessive duration and without adequate monitoring. Resident 10 received Diphenhydramine (Benadryl) in excessive dose and duration.<br><br>Findings:<br><br>1. Clinical record review performed on 4/16/08 at 11 a.m., revealed that Resident 11 had multiple diagnoses that included Depression and Insomnia. He had the following physicians order that was still in effect, " 8/7/07 Ambien CR 6.25 mg PO QHS " . QHS meant that it regularly scheduled to be given every night at bedtime. This medication remained a regularly scheduled drug even though the pharmacist had recommended that it be changed to a prn. (as needed) on 7/28/07. A gradual dose reduction had not been attempted since the inception of this order.<br><br>Mosby ' s Nursing Drug Reference documented that this medication was only for short term use and may be habit forming. Listed side effects for | F 329 | Procedure for identifying other residents potentially affected<br>On April 29, 2008, facility conducted a recapitulation of all medication orders to rule out medication errors relating to the nature of this deficiency. The results of the findings were given to the DON for analysis and corrective action.<br><br>Systemic Changes and Quality Assurance Monitoring<br>Effective immediately a quality assurance process was implemented wherein the pharmacy consultant will be required to review all previous recommendations to verify whether or not facility physicians agree or disagree with the original recommendations. This information will be documented as a supplemental report and presented to the director of nurses for further follow up with physicians in order to facilitate completion of drug regimen review recommendations. | |

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| VETERANS HOME OF CALIFORNIA - BARSTOW | 100 EAST VETERANS PARKWAY BARSTOW, CA 92311 |

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| F 329 | Continued From page 10<br>Ambien included headache, lethargy, dizziness, anxiety, confusion, irritability, amnesia, poor coordination, daytime sedation, nausea, vomiting, diarrhea and heart palpitations. Monitoring for hours of sleep and side effects were to be documented on the MAR (medication administration record). The MAR for March and April 2008 had two columns designated as SE (side effects). One designated as Day and one as Noc (night). The NOC columns had zeros for each night indicating no side effects and the Day columns had 1 ' s 2 ' s and zeros.<br><br>Nursing staff administering medication on the afternoon of 4/17/08 stated that the day column actually documented only hours of sleep during the day and not any other potential side effects.<br><br>On 4/17/08 at 11:20 AM during interview with administrative nursing staff, she acknowledged that neither a gradual dose reduction had been attempted nor had adequate monitoring for side effects been performed for the administration of Ambien for Resident 11.<br><br>2. Clinical record review conducted on 4/14/08 at 10:40 a.m., indicated that Resident 10, a 91year old resident with diagnoses that included Benign Prostate Hypertrophy (BPH), Glaucoma, history of falls and cognitive impairment, had an order dated 1/29/08 for Benadryl (diphenhydramine) 25 mg (milligrams) PO (by mouth) q8h (every 8 hours) PRN (as needed) for itching. Resident 10 had the potential to receive Diphenhydramine 75 mgs daily. The dose should be used in the smallest possible dosage.The order was still in effect. This medication order carried over to the February 2008 and March 2008 Medication | F 329 | | |

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| F 329 | Continued From page 11<br>Recap Reports (MRR) as a standing order.<br><br>Lexicomp Drug Information Handbook, 14th Edition, 2006-2007, page 476 documents that Benadryl (diphenhydramine), an antihistamine H-1 blocker is used for symptomatic relief of allergic symptoms. It also documents that diphenhydramine has high sedative and anticholinergic properties, and it may not be considered the antihistamine of choice in the elderly.<br><br>Dosage duration for diphenhydramine should be for the shortest possible duration (less than 14 days) especially in individuals susceptible to anticholingergic side effects such as urinary retention (difficulty urinating), dry mouth, blurry vision, confusion, cognitive impairment, excessive sedation and may lead to other adverse consequences such as falls.<br><br>During an interview on the same date and time with administrative nursing staff, they acknowledged that diphendramine order should be reassessed for Resident 10. | F 329 | | |
| F 425 SS=D | 483.60(a),(b) PHARMACY SERVICES<br><br>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.<br><br>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet | F 425 | F 425 483.60(a),(b) *Pharmacy Services: It is the policy of the Veterans Home of California-Barstow to provide routine and emergency drugs and biologicals to the residents.* *(cont. next page)* | |

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| F 425 | Continued From page 12<br>the needs of each resident.<br><br>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, document review, and policy and procedure review, the facility failed to ensure that (1) emergency kit was not used to administer routine medications to residents, (2) medications were not stored randomly in the emergency kits, and (3) when opened, the oral emergency kit containing controlled substances (morphine, Tylenol with Codeine, Vicodin) would be resealed according to policy and procedure.<br><br>Findings:<br><br>1. During inspection of the medication room on 4/14/08 at approximately 12 p.m., the Facility Emergency Kit Log was reviewed. The review indicated that medications from the oral emergency kit were removed and administered to residents on a routine basis. On 3/22/08 at 5 p.m., 3/23/08 at 8 a.m. and 3/23/08 at 5 p.m. and 3/24/08 at 8:45 a.m. Cipro 500 mg (milligram) tablets were administered to the same resident (Resident A). On /5/08 at 6 p.m. and 4/6/08 at 11 a.m., Ativan 0.5 mg tablets were administered to Resident B. When interviewed on the same date and time, administrative nursing staff was unable to explain when the emergency kit drugs were | F 425 | Corrective Action<br>Please note that this was an isolated incident. Licensed nursing staff have received training on policies and procedures for proper use of the emergency medication kit. However, in order to enhance currently compliant operations, under the direction of the director of nurses, all licensed nursing staff will receive refresher training regarding the proper procedures for the emergency medication kit on or before June 4, 2008.<br>Procedure for identifying other residents potentially affected<br>As all residents may be potentially affected the Veterans Home of California-Barstow will take corrective action in relation to all residents. Therefore, no procedure for identifying potentially affected residents is necessary.<br>Systemic Changes and Quality Assurance Monitoring<br>Effective immediately licensed nurses are required to visually inspect the emergency medication kit each shift. The results of the inspection will be documented each<br>(cont. next page) | 6-4-08 |

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| F 425 | Continued From page 13<br>used on a routine basis.<br><br>2. During inspection of the medication room on 4/14/08 at approximately 12 p.m., the facility's oral Emergency Kit was inspected. The inspection indicated that medications from the oral emergency kit were stored randomly and unorganized which did not allow nursing staff to readily retrieve a drug for use in an emergency.. When asked to retrieve the vial containing morphine soluble 10 mg tablet as listed on the 'list of contents', the nurse search the kit for 5 minutes, reading each vial picked up.<br><br>3. During inspection of the medication room on 4/14/08 at approximately 12 p.m., the facility's oral Emergency Kit was inspected. When opened, the oral emergency kit containing controlled substances (Morphine, Tylenol with Codeine, Vicodin) was not resealed according to policy and procedure titled, "Patient Care Manual, EMERGENCY DRUG SUPPLY, effective November 17, 2004. Section 7 reads, "A designated yellow lock is to be used to reseal the Emergency Box.(Kit)" The nurse returned the emergency kit to the cabinet without resealing it. When asked the nurse reported that the kits are not resealed after opening. This practice conflicts with the facility's policy and procedure. | F 425 | shift. If the kit is discovered to have been opened, a fax will be sent to the pharmacy requesting a replacement kit, within 24 hours. | |
| F 428<br>SS=D | 483.60(c) DRUG REGIMEN REVIEW<br><br>The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.<br><br>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. | F 428 | F 428, 483.60 (c) *Drug Regimen Review: It is the policy of the Veterans Home of California-Barstow to conduct a drug regimen review monthly for each resident by a licensed pharmacist.*<br>(cont. next page) | |

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| F 428 | Continued From page 14<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on facility staff interview and clinical record review, the pharmacist 's drug regimen review report of irregularities was not acted upon for one of 14 sampled residents (Resident 11).<br><br>Findings:<br><br>Clinical record review performed on 4/16/08 at 11 a.m., revealed that Resident 11 had multiple diagnoses including Depression and Insomnia. He had the following physicians order that was still in effect, " 8/7/07 Ambien CR 6.25 mg PO QHS " . QHS meant that it regularly scheduled to be given every night at bedtime.<br><br>The drug regimen review dated 7/28/07, documented that the pharmacist had recommended that Resident 11 ' s Ambien order be changed to prn. (as needed) rather than be automatically given every night. This medication remained a regularly scheduled drug and there was no documented evidence that Resident 11 ' s physician had reviewed this recommendation and decided that it was not a viable one.<br><br>On 4/14/08 at 11:20 AM during interview with administrative nursing staff, she acknowledged that the physician had not followed the pharmacist ' s recommendation and gave no rational for not doing so. | F 428 | Corrective Action<br>Please note that resident number 11's medication order for Ambein was changed to prn on April 18, 2008. In order to enhance currently compliant operations, under the direction of the director of nurses, all licensed nursing staff will receive refresher training regarding proper procedures for medication administration on or before June 4, 2008.<br><br>Procedure for identifying other residents potentially affected<br>On April 29, 2008, the facility conducted a recapitulation of all medication orders to rule out other medication errors related to the nature of this deficiency. The results of the findings were given to the DON for analysis and corrective action.<br><br>Systemic Changes and Quality Assurance Monitoring<br>Effective immediately a quality assurance process was implemented wherein the pharmacy consultant<br>(cont. next page)<br><br>[F 493 Starts middle of page 16] | 6-4-08 |
| F 493 SS=G | 483.75(d)(1)-(2) GOVERNING BODY<br><br>The facility must have a governing body, or | F 493 | | |

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| F 493 | Continued From page 15<br>designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility; and the governing body appoints the administrator who is licensed by the State where licensing is required; and responsible for the management of the facility<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and record review, the facility failed to ensure that the Policy and Procedure for Alcohol Consumption Control was implemented to 1 of the 1 sampled resident (Resident 8), who was reported and documented to be consuming alcohol in the facility while taking pain, cardiac, and psychotropic medications.<br><br>Findings:<br><br>On 4/15/08 at 8 a.m., an observation of Resident 8 was conducted. Resident 8 was observed in the group area of Pod 400, dressed appropriately and talking with the staff. The resident was also observed to be alert, oriented, and communicating without difficulty. Resident 8 was then observed walking to his room independently and without use of any assistive device.<br><br>On 4/15/08 at 9 a.m., a record review of Resident 8 was conducted. The review indicated that Resident 8 is an 86 year old male, who was originally admitted in the facility on 2/26/06, with diagnoses of Generalized Pain, Congestive Heart Failure (CHF), Hypertension (HTN), Coronary Arterial Disease (CAD), Chronic Obstructive Pulmonary Disease (COPD), Dyslipidemia, | F 493 | will be required to review all previous recommendations to verify whether or not facility physicians agree or disagree with the original recommendations. This information will be documented as a supplemental report and presented to the director of nurses for further follow through with physicians in order to facilitate completion of drug regimen review recommendations.<br><br>F 493, 483.75(d)(1)(2) *Governing Body: It is the policy of the Veterans Home of California-Barstow to maintain a Governing Body that is legally responsible for establishing and implementing policies regarding the operation of the facility.*<br><br>Corrective Action<br>Please note that Veterans Home of California-Barstow makes every effort reasonably possible to have the residents follow the Alcohol Consumption Policy. Resident number 8 is aware of the facilities policy regarding Alcohol Consumption Control. However, resident number 8 is<br>(cont. next page) | 4-22-08 |

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| F 493 | Continued From page 16<br>Depression, and Anxiety.<br><br>On the same date and time, a review of Resident 8's Medication Recap Report dated 11/14/07 was conducted. The review indicated that there was an order by the physician that Resident 8 may go outside the facility on pass with a responsible party. On the same date and time, another review of the Medication Recap Report dated 3/29/08 was conducted. The review indicated that Resident 8 is taking multiple medications which include: Vicodin for generalized pain, Aldactone and Lasix for CHF, Toprol XL for HTN, Amiodarone for Cardiac Arrhythmia (abnormal heart rhythm), Nitroglycerin for chest pain, Crestor for Hypercholesterolemia (high cholesterol), Celexa, Cymbalta, Seroquel, Trazodone for Depression, and Ativan for Anxiety. On the same report, a hand written addendum was made on 3/29/08 at 3 p.m., it indicated, "Librium 25 mg (milligram) PO (by mouth) 1 TID (three times a day) (ETOH [Alcohol] withdrawal x 1 wk [week])."<br><br>On 4/15/08 at 4:40 p.m., an interview with the Chief Medical Officer (CMO) was conducted. The CMO stated that she's familiar with Resident 8 and his wife, and had treated them in the past. The CMO also stated that Resident 8 is getting treatment from a psychiatrist outside the facility and was prescribed with a medication called Seroquel. She further stated, "The [Resident 8] and his wife are very aware of their psychotropic and pain medication. When the medications are decrease or modified, they go back to their outside psychiatrist and get them back to the dosage they were at before, they're the [ Resident 8's last name]." | F 493 | permitted to leave the facility freely and occasionally returns with contraband such as alcohol and will hide these items in his room in an effort to deceive staff. Please note that this was an isolated incident with resident number 8 and it is a rare occurrence for residents to return to the ICF after consuming alcohol. In order to enhance currently compliant operations a care plan was developed for resident number 8 on April 17, 2008, to provide staff interventions to address alcohol related problems. An interdisciplinary team meeting was held on April 22, 2008, and the resident was reeducated regarding the dangers of mixing alcohol with medication, particularly, the potential adverse drug reactions.<br>Resident gave an oral contract to refrain from any further use of alcohol. Additionally, nursing staff were in-serviced on the new care plan beginning April 17, 2008.<br>(cont. next page) | |

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| F 493 | Continued From page 17<br>On 4/16/08 at 9:55 a.m., an interview with the Certified Nursing Assistant 1 (CNA1) was conducted. CNA1 stated that she's been taking care of Resident 8 on and off for less than a year. She also stated, "I have never seen him [Resident 8] cry or depressed. He's just very quiet, but when you ask him questions, he'll answer." She further stated that she had never observed Resident 8 having problems with his speech or gait while taking care of him during morning shift.<br><br>On 4/16/08 at 10 a.m., an interview with the Certified Nursing Assistant 2 (CNA2) was conducted. CNA2 stated that she had never seen Resident 8 cry or depressed. However, she stated that Resident 8 spend most of his time in his room. CNA2 further stated that she had not observed Resident 8 intoxicated, unsteady gait, and slurred speech while taking care of him during morning shift.<br><br>On 4/16/08 at 11:20 a.m., an interview with the Unit Physician was conducted. The Unit Physician stated, "Resident 8 has a psychiatric disorder which includes two extremes, Anxiety and Depression." The Unit Physician also stated that on 3/28/08, four bottles of hard liquor were found in the room of Resident 8 and believe to be ingesting alcohol along with his psychotropic, pain, and cardiac medications. The Unit Physician further stated that Librium was ordered for Resident 8's ETOH (alcohol) withdrawal.<br><br>On 4/16/08 at 11:45 a.m., a review of the Physician's Orders dated 3/8/08 was conducted. The record indicated, "Blood ETOH level." The order was made to check Resident 8's blood alcohol level. The entire Physician's Orders were | F 493 | Procedure for identifying other residents potentially affected<br>On May 9, 2008, the Chief of Social Work audited all charts and revised and updated the list of those residents who have the potential for substance abuse. This list will precipitate those residents who will receive care plan interventions and counseling.<br><br>Systemic Changes and Quality Assurance Monitoring<br>Upon admission all Residents will sign a sobriety contract and agree to abstain from hard alcohol and/or overindulgence.<br>Effective April 17, 2008, a policy and procedure addendum was implemented to include:<br>• Offering inpatient treatment for alcohol rehabilitation at Loma Linda VA Medical Center.<br>• Contacting family members to participate in an (cont. next page) | |

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| F 493 | Continued From page 18<br>reviewed dating back to 3/07 up to 3/29/08, however, there were no other records found indicating that the facility was continuously monitoring Resident 8's blood alcohol level since he was reported drinking on 3/31/07. On the same date and time, a review of the Physician's Orders written on 3/29/08 was conducted. The record indicated, "Librium 25 mg (milligram) PO (by mouth) 1 q (every) TID (three times a day) for ETOH withdrawal x 1 wk. (week)."<br><br>On 4/16/08 at 1 p.m., a review of the Patient's Laboratory Report dated 3/10/08 was conducted. The record showed results from the order made by the physician on 3/8/08 to check Resident 8's blood alcohol level. The record indicated: Test Name = Alcohol, Result = 1, Reference Range = 0.0 - 100, Units = mg/dl<br><br>On 4/16/08 at 1:30 p.m., a review of Nursing Notes was conducted. The review indicated that on 3/31/07 at 9:06 a.m., an entry was made by a staff regarding Resident 8's consumption of alcohol in the facility. The documentation specified, "Resident's wife came to nursing station at 0630 am and reported to this writer that her husband had been drinking all night. Resident room was searched and a bottle of Whiskey was found under bedside table approx. half full and a full bottle of Cream Liqueur was taken from room unopened. Resident assessed for alcohol intoxication. [Unit Doctor] notified at 0830 today with orders to obtain a LFT (Liver Function Test) and Magnesium level on Monday and to have Social Services see resident on Monday. Resident informed that alcohol may not be kept in room and consumed when he wants to. DON [Director of Nursing] informed of above." | F 493 | • Interdisciplinary Team Meeting (IDT) to obtain family support.<br>• Blood alcohol count screens per MD order as clinically indicated.<br>• Care planning and social service counseling to provide interventions and education to address alcohol related problems such as mixing alcohol and medications (Adverse Drug Reaction).<br><br>Additionally, as a quality assurance measure the Chief of Social Work will meet with facility social workers to discuss and analyze the efficacy of interventions and counseling for those residents who are determined to have a propensity for substance abuse. The results of the meetings will be documented and presented at the quarterly quality assurance meeting for further review and corrective action. (cont. next page) | |

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| F 493 | Continued From page 19<br>On 4/16/08 at 1:45 p.m., a review of the Report of Consultation documented by the contracted Psychiatrist on 5/24/07 was conducted. The report indicated, "Pt. [Patient] is anxious, c/o (complaint of) wife not doing well and attempting to justify his use of ETOH because of marital problem ....."<br><br>On the same date and time, another review of Nursing Notes was conducted. The review indicated that on 3/28/08 at 1:54 p.m., another entry was made by a staff regarding Resident 8's consumption of alcohol in the facility. The review indicated, "Housekeeping staff reports while cleaning up res. couple room, noted a can of Sparks with alcohol content of 6%. Res. mostly argumentative and medication seeking. When further checked other areas of the room, staff found an empty bottle of Seagrams (1.75 Liters or 40% alcohol); empty bottle of Christian Bros. very smooth; and almost full opened bottle of Vodka (1.75 Liters of 40% alcohol). MD [Unit MD] aware. [Charge Nurse] notified; Supervising Registered Nurse [SRN] notified. [SS], Social services notified, [DON] made aware."<br><br>On 4/16/08 at 2:35 p.m., a review of the Physician's Progress Notes written on 3/29/08 was conducted. The record indicated, "Pt. was taking Vodka, Brandy, Whiskey regularly everyday getting anxious and had frequent falls. C/O withdrawal symptoms like anxiety, shakiness .....A/P (Assessment/Plan): ETOH abuse, ETOH Dependence, Plan: D/C (Discontinue Ativan, Xanax, start Librium 25 mg TID."<br><br>On 4/17/08 at 8:45 a.m., an interview with the Licensed Vocational Nurse (LVN) was conducted. The LVN stated that she's familiar with Resident | F 493 | | |

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| F 493 | Continued From page 20<br>8. She further stated, "I found four bottles of alcohol and 1 of the bottles is almost full (Vodka). They were found inside the closet approximately three weeks ago." She also stated that Resident 8 was very belligerent on the day they found the bottles of alcohol and it was out of Resident 8's character to yell at the LVN, reason why she suspected that the Resident 8 is taking more than his medications. The LVN further stated that she had not observed Resident 8 intoxicated or under the influence during morning and night shift that she was on, however she was told in the past by a family member that the resident has an alcohol problem before coming into the facility.<br><br>On 4/17/08 at 9:25 a.m., an interview with the Psychiatric Social Worker (PSW) was conducted. The PSW stated that Resident 8 was counseled in the past for consuming alcohol in the facility. A Code of Conduct Violation Report was also written on 3/28/08 for the consumption of alcohol. An Interdisciplinary Team (IDT) meeting was conducted on 4/15/08 and according to the PSW, Resident 8 denied consuming alcohol or having an alcohol problem, which was reflected in the in the IDT notes. The PSW further stated, "Yes, there's an issue with the resident drinking alcohol in the facility."<br><br>On 4/17/08 at 10:15 a.m., a review of the facility's Policy and Procedure with an effective date of 8/3/05 and titled "Alcohol Consumption Control" was conducted. The record indicated, "POLICY STATEMENT(S): 4. Only beer and wine will be served within the facility. No hard liquor will be available. Non-alcoholic beer and wine will be offered during facility events." The review further indicated, "POLICY STATEMENT(S): 12. The facility reserves the right to refuse to serve | F 493 | | |

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| F 493 | Continued From page 21<br>alcohol when staff is aware that a resident's medication and/or an individual's personal reaction after ingesting alcohol may place the facility at risk. Employees of the Home will not serve these individuals. 13. On admission residents history and physical shall include alcohol related problems and if residents request approval for alcohol consumption. The Medical Staff shall be responsible for noting in the chart those residents who are able to have alcohol."<br><br>On 4/17/08 at 10:45 a.m., a review of the facility's "Resident Code of Conduct" was conducted. The record indicated, "IV. PROHIBITED CONDUCT - The following conduct will not be tolerated: 9. Drunkenness and any disorderly conduct on the grounds. A resident shall not possess any of the following while on Home grounds: 2. Alcohol in unauthorized areas."<br><br>On 4/17/08 at 3:15 p.m., an interview with Resident 8 was conducted. Resident 8 stated that he hasn't had any drink for a while and that he had never been an alcoholic. However, he stated that he had been treated for alcohol abuse twenty years ago and was sober for fifteen years. When Resident 8 was told that there were 4 bottles of hard liquor found in his room on 3/28/08 in which of one was almost full, he admitted that he head been drinking inside his room at night time. He also stated, "I drink about two to four ounces of liquor every three days and when I'm anxious, but I never get drunk. The four bottles of liquor found in my closet had been there for the past three months." Resident 8 was asked how he was getting the alcohol inside the facility. He stated, "I have a free pass (go outside the facility on pass with a responsible party) and I buy it myself, no one is bringing it to me." Resident 8 | F 493 | | |

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| F 493 | Continued From page 22<br>further stated his reason for drinking was due to his financial and physical problem, stating, "I can't do what I used to do anymore." | F 493 | | |
| F 497 SS=E | 483.75(e)(8) REGULAR IN-SERVICE EDUCATION<br><br>The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. The in-service training must be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year; address areas of weakness as determined in nurse aides' performance reviews and may address the special needs of residents as determined by the facility staff; and for nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on facility staff interview and review of personnel and continuing in-service education records, the facility failed to evaluate the work performance for 12 of 26 CNAs (certified nurse aides) at least every 12 months. It also failed to ensure that 2 of 26 CNAs were provided with at least 12 hours of annual in-service training.<br><br>Findings:<br><br>1. On 4/23/08 at 2:10 p.m., review of CNA personnel records revealed that one CNA ' s last work performance evaluation had been in 2003, another CNA's last evaluation had been in 2004 and six other CNAs had their most recent | F 497 | F 497, 483.75(e)(8) *Regular In-service Education: It is the policy of the Veterans Home of California-Barstow to complete annual performance reviews of all nursing staff as well as regular in-service education.*<br><br>Corrective Action<br>Please note that the 2 of the 26 certified nursing assistants referenced did complete their required annual in-service education on May 15, 2008. Additionally all certified nursing assistants were provided with documentation detailing the requirements for in-service education as well as a list of the facility's current in-service schedule. Furthermore, the 12 Certified Nursing Assistances referenced did have their performance evaluations completed as of May 15, 2008.<br><br>Procedure for identifying other residents potentially affected<br>On May 10, 2008, the Nurse Instructor conducted an audit on all Certified Nursing Assistants to verify continuing education. (cont. next page) | 5-15-08 |

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| F 497 | Continued From page 23<br>evaluation performed in 2006.<br><br>On 4/23/08 at 2:45 PM, administrative nursing staff stated that she knew they were behind in their evaluations and that she attributed it to turnover in supervisory nursing staff.<br><br>2. On 4/23/08 at 2:50 p.m., review of CNA in-service training records revealed that one CNA had only received 7 hours of training in the past 12 months.<br><br>On 4/23/08 at 3:15 PM, during interview with the facility ' s nurse educator, she attributed this lack of minimum annual training to this particular CNA ' s repeated failure to attend training sessions.<br><br>3. On 4/23/08, at 9:30 p.m., review of CNA in-service training records revealed that one staff had not met the minium of 12 hours of in-service training as she had only attended 10 hours in tha past year. | F 497 | Systemic Changes and Quality Assurance Monitoring<br>Effective May 19, 2008, a monthly quality assurance process was implemented by the Nurse Instructor wherein she will randomly select five nursing staff training files and inspect them to verify that staff are regularly attending in-service training to comply with requirements. Additionally, the human resource technician will be required to check the employee database on a monthly basis to verify completion dates for employee performance evaluations. The human resource technician will then notify individual department heads regarding those employees requiring performance evaluations. The results of the inspection will be documented and presented to the quality assurance committee for review. | |
| F 514<br>SS=D | 483.75(l)(1) CLINICAL RECORDS<br><br>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.<br><br>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. | F 514 | F 514, 483.75 (l)(1) *Clinical Records: It is the policy of the Veterans Home of California-Barstow to maintain clinical records on each resident in accordance with acceptable professional standards.*<br>*(cont. next page)* | |

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| F 514 | Continued From page 24<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and clinical record review , the facility failed to ensure that a medication (Celebrex) order was correctly transcribed on the Medication Recap Report for 1 of 14 sampled residents (Resident 4).<br><br>Findings:<br><br>Following the Medication Pass Observation conducted on 4/14/08 at approximately 9:10 a.m., review of the clinical record was conducted. The review indicated that a physician's order for a routine drug (Celebrex) had been transcribed incorrectly to the Medication Recap Report (MRR). The order documented on the MRR read, Celebrex 1 cap (capsule) 200mg (milligram) PO (by mouth) PRN (as needed), whereas, the physician's order read, "Celebrex 200 mg (milligrams) 1 PO (by mouth) QD (daily) for joint pain.<br><br>Licensed did not transcribe the medication unto the MRR as prescribed by the physician, therefore, Resident 4 had the potential to receive more than one dose daily as ordered by the physician.<br><br>When interviewed on the same date and time, licensed staff reported that Celebrex should be given as ordered by the physician. | F 514 | Corrective Action<br>Please note on April 14, 2008, the order for Celebrex was discontinued per physician's order. Under the direction of the director of nurses, on or before June 4, 2008, all licensed nurses will be in serviced regarding proper procedures for transcription of medical orders.<br>Procedure for identifying other residents potentially affected<br>On April 29, 2008, facility conducted a recapitulation of all medication orders to rule out transcription errors. The results of the findings were given to the DON for analysis and corrective action.<br>Systemic Changes and Quality Assurance Monitoring<br>On May 19, 2008, quality assurance process was implemented where in the DON or selected designee will conduct an audit of five randomly selected charts and perform a cross-comparison of medication orders with Medication Administration Record (MAR). | 6-4-08 |
| F 518 SS=E | 483.75(m)(2) DISASTER AND EMERGENCY PREPAREDNESS<br><br>The facility must train all employees in emergency procedures when they begin to work in the facility; periodically review the procedures with existing staff; and carry out unannounced staff drills using | F 518 | F 518, 483.75(m)(2) *Disaster and Emergency preparedness: It is the policy of the Veterans Home of California-Barstow to train all employees in emergency procedures.*<br>(cont. next page) | |

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| F 518 | Continued From page 25<br>those procedures.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on review of facility Fire Drill Reports for March 2007-March 2008 and staff interview, the facility has failed to take corrective action on documented problems experienced during fire drills.<br><br>Finding:<br><br>1) 09/19/07, " A402 propped open with wedge. No staff in 400 POD/300. "<br><br>2)09/19/07, Blood pressure machine plugged in hallway. "<br><br>3) 04/22/07, " Resident did not go to room. Finally consented to go to activity room " .<br><br>4) 03/01/07, " Telephone 333 was busy during drill so that proper notification could not be made " .<br><br>5) " Resident staff need in-service. "<br><br>When Administrative staff was asked on 4/16/08, at 10:30 a.m. why no corrective action for documented issues, was found on Fire Drill Report, staff stated that that part of drill had not been filled in.<br><br>A review of facility Safety and Emergency Planning Manual on 4/23/08, at 2 p.m. stated: "Fire Plan VH-05-0080. F. Fire Drills... The documentation of the fire drills shall be summarized to identify weaknessess in the | F 518 | Corrective Action<br>Please note on April 14, 2008, facility implemented a new format for fire drill reports that is now more user friendly. The new report also details required specifications for conducting drills and a section for summarizing drill activity and participation. Additionally, all staff will be in-serviced on or before June 4, 2008, regarding new fire drill form and disaster and emergency preparedness.<br>Procedure for identifying other residents potentially affected<br>As all residents may be potentially affected the Veterans Home of California-Barstow will take corrective action in relation to all residents. Therefore, no procedure for identifying potentially affected residents is necessary.<br>Systemic Changes and Quality Assurance Monitoring<br>Effective May 19, 2008, a quality assurance program was implemented wherein the Standards and Compliance Coordinator will inspect monthly drill reports to verify disaster and emergency preparedness procedures are followed properly and that fire drill reports are completed accurately. | 6-4-08 |

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| F 518 | Continued From page 26<br>overall plan, specific weaknessess in areas, and plans for improvement." | F 518 | F 520, 483.75(o)(1) *Quality Assessment and Assurance: It is the policy of the Veterans Home of California-Barstow to maintain a quality assessment and assurance committee with required staff.* | |
| F 520 SS=D | 483.75(o)(1) QUALITY ASSESSMENT AND ASSURANCE<br><br>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.<br><br>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.<br><br>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.<br><br>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview, and record review, the facility failed to develop and implement appropriate plans of action to correct identified quality deficiencies, when 1 of 14 sampled residents (Resident 8) was reported and documented to be consuming alcohol in the facility at night time while taking pain medications, | F 520 | Corrective Action<br>Please note that the quality assurance committee does meet on a quarterly basis to develop and implement plans to address care and operational issues that impact the lives of the residents. In order to enhance currently compliant operations, under the direction of the director of nurses, the quality assurance committee will receive in-service training on or before June 4, regarding the process of tracking "Key Area Actions."<br><br>Procedure for identifying other residents potentially affected<br>As all residents may be potentially affected the Veterans Home of California-Barstow will take corrective action in relation to all residents. Therefore, no procedure for identifying potentially affected residents is necessary. (cont. next page) | 6-4-08 |

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| F 520 | Continued From page 27<br>cardiac medications, and psychotropic medications.<br><br>Findings:<br><br>On 4/15/08 at 9 a.m., a clinical record review of Resident 8 was conducted. The review indicated that Resident 8 is an 86 year old male who was originally admitted in the facility on 2/26/06 with diagnoses of Generalized Pain, Congestive Heart Failure (CHF), Hypertension (HTN), Coronary Arterial Disease (CAD), Chronic Obstructive Pulmonary Disease (COPD), Dyslipidemia, Depression, and Anxiety.<br><br>On the same date and time, a review of Resident 8's Medication Recap Report dated 11/14/07 was conducted. The review indicated that there was an order by the physician that Resident 8 may go outside the facility on pass with a responsible party. On the same date and time, another review of the Medication Recap Report dated 3/29/08 was conducted. The review indicated that Resident 8 is taking multiple medications which include: Vicodin for generalized pain, Aldactone and Lasix for CHF, Toprol XL for HTN, Amiodarone for Cardiac Arrhythmia (abnormal heart rhythm), Nitroglycerin for chest pain, Crestor for Hypercholesterolemia (high cholesterol), Celexa, Cymbalta, Seroquel, Trazodone for Depression, and Ativan for Anxiety. On the same report, a hand written addendum was made on 3/29/08 at 3 p.m., it indicated, "Librium 25 mg (milligram) PO (by mouth) 1 TID (three times a day) (ETOH [Alcohol] withdrawal x 1 wk [week])."<br><br>On 4/15/08 at 4:40 p.m., an interview with the Chief Medical Officer (CMO) was conducted. The | F 520 | Systemic Changes and Quality Assurance Monitoring<br>Each quarter the Hospital Administrator of the Veterans Home of California-Barstow will be responsible to review and summarize all quality assurance issues that are tracked as "Key Area Actions." Results of the summary reports will be maintained by the administrator for further review and corrective action.<br><br>-30- | |

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| F 520 | Continued From page 28<br>CMO stated that she's familiar with Resident 8 and his wife, and had treated them in the past. The CMO also stated that Resident 8 is getting treatment from a psychiatrist outside the facility and was prescribed with a medication called Seroquel. She further stated, "The [Resident 8's last name] are very aware of their psychotropic and pain medication. When the medications are decrease or modified, they go back to their outside psychiatrist and get them back to the dosage they were at before, they're the [ Resident 8's last name]."<br><br>On 4/16/08 at 9:55 a.m., an interview with the Certified Nursing Assistant 1 (CNA1) was conducted. CNA1 stated that she's been taking care of Resident 8 on and off for less than a year. She also stated, "I have never seen him [Resident 8] cry or depressed. He's just very quiet, but when you ask him questions, he'll answer." She further stated that she had never observed Resident 8 having problems with his speech or gait while taking care of him during morning shift.<br><br>On 4/16/08 at 10 a.m., an interview with the Certified Nursing Assistant 2 (CNA2) was conducted. CNA2 stated that she had never seen Resident 8 cry or depressed. However, she stated that Resident 8 spend most of his time in his room. CNA2 further stated that she had not observed Resident 8 intoxicated, unsteady gait, and slurred speech while taking care of him during morning shift.<br><br>On 4/16/08 at 11:20 a.m., an interview with the Unit Physician was conducted. The Unit Physician stated, "Resident 8 has a psychiatric disorder which includes two extremes, Anxiety | F 520 | | |

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| F 520 | Continued From page 29<br>and Depression." The Unit Physician also stated that on 3/28/08, four bottles of hard liquor were found in the room of Resident 8 and believe to be ingesting alcohol along with his psychotropic, pain, and cardiac medications. The Unit Physician further stated that Librium was ordered for Resident 8's ETOH (alcohol) withdrawal.<br><br>On 4/16/08 at 11:45 a.m., a review of the Physician's Orders dated 3/8/08 was conducted. The record indicated, "Blood ETOH level." The order was made to check Resident 8's blood alcohol level. The entire Physician's Orders were reviewed dating back to 3/07 up to 3/29/08, however, there were no other records found indicating that the facility was continuously monitoring Resident 8's blood alcohol level since he was reported drinking on 3/31/07. On the same date and time, a review of the Physician's Orders written on 3/29/08 was conducted. The record indicated, "Librium 25 mg (milligram) PO (by mouth) 1 q (every) TID (three times a day) for ETOH withdrawal x 1 wk. (week)."<br><br>On 4/16/08 at 1 p.m., a review of the Patient ' s Laboratory Report dated 3/10/08 was conducted. The record showed results from the order made by the physician on 3/8/08 to check Resident 8 ' s blood alcohol level. The record indicated: Test Name = Alcohol, Result = 1, Reference Range = 0.0 - 100, Units = mg/dl<br><br>On 4/16/08 at 1:30 p.m., a review of Nursing Notes was conducted. The review indicated that on 3/31/07 at 9:06 a.m., an entry was made by a staff regarding Resident 8's consumption of alcohol in the facility. The documentation specified, "Resident's wife came to nursing station at 0630 am and reported to this writer that | F 520 | | |

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|---|---|---|---|
| | 05A419 | A. BUILDING _____ B. WING _____ | 04/23/2008 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| VETERANS HOME OF CALIFORNIA - BARSTOW | 100 EAST VETERANS PARKWAY BARSTOW, CA 92311 |

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| F 520 | Continued From page 30<br>her husband had been drinking all night. Resident room was searched and a bottle of Whiskey was found under bedside table approx. half full and a full bottle of Cream Liqueur was taken from room unopened. Resident assessed for alcohol intoxication. [Unit Doctor] notified at 0830 today with orders to obtain a LFT (Liver Function Test) and Magnesium level on Monday and to have Social Services see resident on Monday. Resident informed that alcohol may not be kept in room and consumed when he wants to. DON (Director of Nursing) informed of above."<br><br>On 4/16/08 at 1:45 p.m., a review of the Report of Consultation documented by the contracted Psychiatrist on 5/24/07 was conducted. The report indicated, "Pt. [Patient] is anxious, c/o (complaint of) wife not doing well and attempting to justify his use of ETOH because of marital problem ....."<br><br>On the same date and time, another review of Nursing Notes was conducted. The review indicated that on 3/28/08 at 1:54 p.m., another entry was made by a staff regarding Resident 8's consumption of alcohol in the facility. The review indicated, "Housekeeping staff reports while cleaning up res. couple room, noted a can of Sparks with alcohol content of 6%. Res. mostly argumentative and medication seeking. When further checked other areas of the room, staff found an empty bottle of Seagrams (1.75 Liters or 40% alcohol); empty bottle of Christian Bros. very smooth; and almost full opened bottle of Vodka (1.75 Liters of 40% alcohol). MD [Unit MD] aware. [Charge Nurse] notified; Supervising Registered Nurse [SRN] notified. [SS], Social services notified, [DON] made aware." | F 520 | | |

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| F 520 | Continued From page 31<br>On 4/16/08 at 2:35 p.m., a review of the Physician's Progress Notes written on 3/29/08 was conducted. The record indicated, "Pt. was taking Vodka, Brandy, Whiskey regularly everyday getting anxious and had frequent falls. C/O withdrawal symptoms like anxiety, shakiness .....A/P (Assessment/Plan): ETOH abuse, ETOH Dependence, Plan: D/C (Discontinue Ativan, Xanax, start Librium 25 mg TID."<br><br>On 4/17/08 at 8:45 a.m., an interview with the Licensed Vocational Nurse (LVN) was conducted. The LVN stated that she's familiar with Resident 8. She further stated, "I found four bottles of alcohol and 1 of the bottles is almost full (Vodka). They were found inside the closet approximately three weeks ago." She also stated that Resident 8 was very belligerent on the day they found the bottles of alcohol and it was out of Resident 8 ' s character to yell at the LVN, reason why she suspected that the Resident 8 is taking more than his medications. The LVN further stated that she had not observed Resident 8 intoxicated or under the influence during morning and night shift that she was on, however she was told in the past by a family member that the resident has an alcohol problem before coming into the facility.<br><br>On 4/17/08 at 9:25 a.m., an interview with the Psychiatric Social Worker (PSW) was conducted. The PSW stated that Resident 8 was counseled in the past for consuming alcohol in the facility. A Code of Conduct Violation Report was also written on 3/28/08 for the consumption of alcohol. An Interdisciplinary Team (IDT) meeting was conducted on 4/15/08 and according to the PSW, Resident 8 denied consuming alcohol or having an alcohol problem, which was reflected in the in the IDT notes. The PSW further stated, " Yes, | F 520 | | |

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| F 520 | Continued From page 32<br>there's an issue with the resident drinking alcohol in the facility."<br><br>On 4/17/08 at 10:15 a.m., a review of the facility's Policy and Procedure with an effective date of 8/3/05 and titled "Alcohol Consumption Control" was conducted. The record indicated, "POLICY STATEMENT(S): 4. Only beer and wine will be served within the facility. No hard liquor will be available. Non-alcoholic beer and wine will be offered during facility events." The review further indicated, "POLICY STATEMENT(S): 12. The facility reserves the right to refuse to serve alcohol when staff is aware that a resident ' s medication and/or an individual's personal reaction after ingesting alcohol may place the facility at risk. Employees of the Home will not serve these individuals. 13. On admission residents history and physical shall include alcohol related problems and if residents request approval for alcohol consumption. The Medical Staff shall be responsible for noting in the chart those residents who are able to have alcohol."<br><br>On 4/17/08 at 2:15 p.m., an interview with the Standard Compliance Coordinator (SCC) was conducted. The SCC described the composition of the QA committee which included the DON, physician, SCC, SRN (Supervising Registered Nurse), and other staff. The SCC was asked how current and ongoing issues were identified for committee action. The SCC stated that the committee checks for quality indicators, going over old business, POC from last year's incident, monitoring, and by used of correction tool. The SCC was also asked how action plans were developed. She stated that the QA (Quality Assurance) committee meets and other multidisciplinary team. The group assesses the | F 520 | | |

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| F 520 | Continued From page 33<br>issue and formulates a plan. She also stated that plans are implemented by having a policy and procedure in place, IDT meetings, and in-service trainings while the SRN, DON, and SCC monitors. She further stated that the QA committee will find ways to address the situation by revisiting the plans that are not achieving or sustaining desired outcomes.<br><br>After staff interview and record review, it was identified that there was non-compliance to the implementation of the policy and procedure on "Alcohol Consumption Control." The facility was aware of Resident 8's consumption of alcohol in the facility since 3/31/07. The DON, who is a member of the QA committee, has knowledge of the issues related to the noncompliance because it was reported to her on two occasions as documented in the Nursing Notes. It was determined that the QA committee failed to consider a quality deficiency, develop a plan, and implement an action plan to address the issue of alcohol consumption in the facility when Resident 8 admitted that he was consuming alcohol for the past three months before the staff discovered bottles of liquor in his closet on 3/28/08. | F 520 | | |